MENTAL HEALTH CONSORTIUM

TRACKING LOG FY 1999

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-O398	Primary Care Seeing Mental Health Patients	COL Hicks and LTC Voepel	ASSIGNED 19 Mar 98	COMPLETED 20 Nov 98	CLOSED

19 Mar 98: COL Hicks is interested in determining how many patients with mental health issues are being seen in Primary Care (Family Practice and APCC). This will assist in the development of treatment guidelines and education of primary care managers. LTC Voepel will assist in this project by gathering data. Expand out to include the other MTFs.
8 May 98: This issue not addressed at this time due to time constraints. Will be discussed at the 5 June 1998 or September meeting.
22 Oct 98: Although not specifically discussed at the meeting, it was addressed during COL Hicks' presentation. Will need clarification as to what data is further needed.
20 Nov 98: Primary Care portals at MAMC are interested in having Behavioral Health assist in the training of residents. As clinical pathways are being developed for the PCMs to treat certain mental health problems, it is determined that this item can be closed at this time. **CLOSED.**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0498	ADS Worksheet	COL Hicks LCDR Richardson	ASSIGNED 19 Mar 98	COMPLETED	

19 Mar 98: Members need to determine the best way to code ADS sheets for the Region. This project is to be initiated by members forwarding individual ADS sheets to LTC Vance (done) for review, analysis, and recommendation.
8 May 98: Preliminary work to develop a Uniform ADS sheet began with preparing a list of approximately 58 diagnoses. Further work will refine the list. Unable to develop consolidated list of E&M Codes, CPT Codes and Dispositions due to time constraints. Will plan to do this by 5 June.
5 June 98: Members reviewed the E&M coding criteria and selected 20 E&M codes that will go on the uniform Mental Health Regional ADS sheet. Started working on a similar process of selecting CPT Codes. CPT coding selection to be completed at the next meeting.
25 Sept 98: The ADS sheet is almost completed. The coding needs to be done by coders. It is anticipated that the sheet will be completed and sent out by 1 October 1998, if coders can accomplish task. A one-page instruction sheet will accompany the form. USCG will voluntarily use the sheets.
23 Oct 98: The issue was discussed by the members. LTC Vance distributed the ICD-9 and CPT codes that would be used on the sheet. A consensus amongst the members was that this would only apply to adults with the exception of Family Advocacy and Substance Abuse. LTC Vance asked the members to review the form for errors, etc. This will be addressed at the next meeting for final approval by the membership.
20 Nov 98: LTC Vance indicated that the sheet was not available for review because of duplication of codes when it was printed. The form will be reviewed and printed. It is anticipated that the form will be available for the next meeting.

CDR Hudack indicated that NH Oak Harbor might obtain NH-21, which allows ADS to be completed on-line. NH-21 is not confined to the 52 codes that are present on the ADS form. NH-21 costs approximately $5000 per node, but the cost savings may be as much as $30,000 per year. The group decided that the ADS would be the template, even if a particular MTF obtained the NH-21 or the Region. This would allow for the gathering of clean data.
16 Dec 98: Continue to have problems with the duplications on the form. Continue to work this issue.
23 Jan 99: ADS coding is being changed by HA. ADS form will need to be re-evaluated when the new "authorized" codes are released and implemented. Champion changed to COL Hicks.
26 Feb 99: Maj Schack commented that the ADS at Fairchild is used for third party billing. The codes need to be out to 5 digits. Most V-codes are non-billable items. The members discussed the impact of EBC and how does the ADS compares to EBC. LTC Voepel will discuss this issue with LT Toland. It is hoped that the final version of the sheet will be ready for approval at the March meeting.
26 Mar 99: The members discussed the ADS sheet. It was decided that nine CPT codes would be removed and replaced. See Attachment C. The members also agreed that secondary diagnoses need to be coded (up to 5). LCDR Richardson will help COL Hicks in revising the ADS form. LTC Voepel will ask LTC David Smith, MAMC PAD Officer, about presenting a briefing on ADS or obtaining a tape of the brief for the members. LtCol Pugh or Maj Schack will provide the members with the name of the tutorial and software concerning ADS or web site. The ADS form will be distributed to the members at the 30 April meeting (or before if possible) and implemented on or about 1 May 99. Collection data will be in 3-6 months.
30 Apr 99: LCDR Richardson reported that the codes were rechecked at NH Bremerton and incorporated what the group submitted at the last meeting. Explained that some codes have multiple uses. Need to check uniformity vs. best uniformity. Alcohol Treatment Programs are to use this form. LCDR Richardson is to resubmit the ADS sheet to the members within the next week or so. Members will need to take the form to their MTF for approval and implementation. The group decided to start using the form on 17 May 1999.
27 May 99: The CPT codes being used are from the 1999 Code Book. There was a discussion concerning the E&M codes: use of level of effort instead of times. It was decided that the codes were fine and that the wording did not need to be changed. The providers need to be instructed (at each MTF) what the codes mean and that level of effort needs to be justified in the chart. LCDR Richardson is to forward to the members an instruction sheet as to what each code means. All MTFs are using the ADS at this time. Discussion of the specific project(s) will take place during the September 1999 meeting.
25 June 99: CAPT Baer distributed for LCDR Richardson an explanation of the CPT Procedure and E&M Codes that are used.
30 Jul 99: As the September 1999 meeting has been cancelled, LTC Voepel was asked to start the ADS research project early. To look at the top 10 diagnoses based on the CPT codes, primary four diagnoses, and top four E&M codes. To look at Region wide and MTF specific data.
27 Aug 99: The members received an outstanding briefing on CPT and E&M coding. The members discussed the possibility of developing a new, different ADS form for ADAPC, ATD, and possibly OCIP. The KGCHCS (automated ADS) system seems to be adding more time the provider's day, as indicated by COL Hicks. The members held preliminary discussions concerning the direction of the research that should take place with the Region 11 standardized ADS form. LTC Voepel to report at the next meeting what are the capabilities of the CEIS system in assisting with data collection, analysis, etc.
29 Oct 99: The members discussed the ADS sheet and the need to resolve issues that have become apparent over the last few months. Kathy Kutscher will be asked to assist in the project of updating the ADS form. This will entail involving Ms. Pegum to determine what codes are allowable for DoD use.

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0598	Critical Incident Stress Management Regionalization	DR Beshore	ASSIGNED 25 Sept 98	COMPLETED	CLOSED

25 Sept 98: Critical Incident Stress Management is a growing concern within the region. Benefits outweigh the costs. An aspect to be considered is the differences in the training between CISM and the Red Cross. Another consideration is which military facility should be the referral center for questions, etc. Dr. Beshore (NHOH) will contact LTC Tyrell-Smith (MAMC) concerning these issues.
22 Oct 98: Dr. Beshore indicated that the program at Oak Harbor is awaiting approval by the installation commander.
20 Nov 98: Commanding Officer Oak Harbor Naval Base has signed the letter authorizing this program. Meetings are scheduled for the first week in December. The plan is to provide further training and explore TQM issues. Health promotion nurses are being trained and will be liaisons with the line units.
23 Jan 99: Naval Hospital Oak Harbor will be the recognized organization within Region 11 for other CISM teams/members to contact for information. **CLOSED.**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0698	Liaison Personnel involved with Mental Health	LTC Vance LTC Voepel	ASSIGNED 25 Sept 98	COMPLETED	CLOSED

25 Sept 98: All military liaison personnel need to be invited to become more involved with mental health issues, especially those dealing with patients. Liaison personnel will be asked to attend one weekly meeting on 5N. The meeting may need to be tailored to include outpatient issues. The benefit(s) of attendance is that coordinated care (proper appointments are made) and discharge planning is carried out. This will also ensure that the parent MTF or organization knows of the admission/discharge/treatment and can take appropriate steps.
23 Oct 98: This issue was not addressed at the meeting.
20 Nov 98: Not addressed at this meeting.
23 Jan 99: The action officers were unable to involve the liaison personnel at MAMC into the weekly meetings. Consortium members were advised that to have this accomplished then the individual MTF (who is responsible for the military liaison member) will need to direct the liaison to attend the weekly discharge-planning meeting. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0798	Certification of RTFs, RTCs, IOPs	LTC Vance	ASSIGNED 25 Sept 98	COMPLETED 23 Jan 99	CLOSED

25 Sept 98: Region 5 Mental Health Consortium has asked Region 11 MHC to join them in addressing the issue of CHAMPUS/TRICARE certification of RTFs, RTCs, and IOPs. The process now is lengthy and cumbersome. Few of these treatment facilities are available within any one region because of the certification process. Beneficiaries are being sent out of the region for care. This seems to have a negative effect on the beneficiary as the immediate family members are not receiving counseling also. Region 6 and FHFS will be invited to join to petition TMA and HA to change the procedure.
23 Oct 98: Members discussed the issue of joining Region 5 in petitioning TMA and HA to review the procedures for certification of RTFs/RTCs/IOPs. Members are to explore the issue with their respective chain-of-command. Members are to indicate whether to support or withdraw from this issue.
20 Nov 98: This issue was discussed during the Contract Extension briefing. The members are all in agreement that JCAHO and/or CARF certification should be sufficient for CHAMPUS certification.

23 Jan 99: TMA has received the recommendations by the members. Although the issue is being closed out for the tracking log, it will be periodically reviewed under Old Business. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0898	Closure of NH Bremerton Inpatient Psychiatric Unit	COL Hicks CAPT Baer	ASSIGNED 25 Sep 98	COMPLETED	As Needed

25 Sept 98: The group discussed the impact of the closure of the inpatient unit at NHB. This will impact all services and MTFs in the Region. MAMC will have the only inpatient unit within the Region. Because of the USCG (GSUs) and Navy fit for duty regulations, MAMC may need to change policies concerning admission of patients for testing and fit for duty boards. All avenues to provide the service(s) at MAMC need to be explored. Proposal to be written that MAMC should accept all active duty inpatient admissions from NHOH, NHB, and USCG. The proposal will include the impact of the closure on the Region.
22 Oct 98: CAPT Baer discussed this issue. No date had been set for the closure of the unit. Action Officer(s) changed from LTC Vance/LTC Voepel to CAPT Baer/COL Hicks.
20 Nov 98: This issue was discussed by the members. The strategy is for the Mental Health personnel to call MAMC when an active duty member needs to be hospitalized. It is not an ER physician to an ER physician mechanism. Only active duty from NH Bremerton will be admitted at this time with the possibility of dependents being provided the service at a later time. All board actions will be done at Bremerton. Harrison County Hospital will be utilized when necessary. A plan to have an observation bed(s) on the medical-surgical ward is being formulated. It would only be utilized for 23 hours 59 minutes. CAPT Baer is working with NH Bremerton Nursing Services concerning coverage, training, and education. A crisis intervention/prevention day center is being proposed. NH Bremerton Mental Health is moving towards an intensive outpatient program. No structural changes to the inpatient unit are anticipated for several months until it has been determined that the closure is truly feasible and workable. As NH Bremerton was the referral center for the Coast Guard and NH Oak Harbor, it was decided that these patients would still be referred to NH Bremerton for evaluation and possible admission. If the patient needs to be admitted, then MAMC would be contacted.
16 Dec 98: System process seems to be working at this time. Patients are being admitted at MAMC and Harrison County. Had to reopen the NH Bremerton unit for one day because of the need to use the seclusion room due to the high census at MAMC. Intensive Outpatient Stress Management Classes at NH Bremerton will start the end of January 1999. These will be primarily aimed at the personnel on submarines.
22 Jan 99: The members discussed the successes and the problems that have occurred over the last few months. There does seem to be a conflict as to the process for referring NH Oak Harbor patients to MAMC. MAMC will work out the process with NHOH and NHB. Questioning the process of all Navy personnel being seen at NHB prior to admission at MAMC. It was noted that the September to December 1998 high inpatient census at MAMC was a variance. Few personnel are being sent to MAMC for admission. COL Hicks indicated that MAMC will continually keep the MTFs and PsychCare (FHFS) advised as to the availability of inpatient services based on the census.
26 Feb 99: The referrals and inpatient admissions from NH Bremerton appear to be working well. A small problem may arise because MAMC Command Group and the Department of Nursing want to be more involved in the decision making process as to when the inpatient unit will close due to increased patient census and the development of such policies.
25 Mar 99: No problems at this time or any item to be discussed. MOU not signed at this time. Will remain open until MOU signed, but will only be discussed when necessary.

25 June 99: This section will also incorporate the issue of transferring beneficiaries, esp. active duty members, to MAMC. The MOU will be modified to reflect this issue. The MOU has not been approved by MAMC at this time. COL Hicks will investigate where in the MOU is at in the approval process.
27 Aug 99: The members discussed the fluctuating inpatient census at MAMC. According to LtCol Drew, McChord will not be able to assist in providing a Mental Health technician for the MAMC inpatient unit because of taskings. The MOU has not been officially signed at this time. Seems to be hung-up in the Department of Nursing, MAMC. COL Hicks to work this issue.
29 Oct 99: This remains an open item, MOU has not been signed at this time. The unofficial MOU is working and there has not been a problem with beneficiaries being admitted to MAMC.

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0199	Regional Practice and Referral Guidelines	COL Hicks All Members	ASSIGNED 23 Oct 98	COMPLETED 29 Oct 99	CLOSED

23 Oct 98: COL Hicks presented the Practice guidelines for Primary Care Managers for Depression. There was discussion of the issue. Members are to discuss issue of using these guidelines on a regional basis with colleagues. Members are to report recommendations at next meeting.
20 Nov 98: Review by members indicated that referral guidelines might not be indicated. This may place too much responsibility upon the PCM and may preclude patients being seen by Mental Health services. Also other specific area items or requirements need to be re-examined. COL Hicks will rework the guideline and present at the next meeting.
22 Jan 99: The members again discussed this issue. PCMs at NH Bremerton and the USCG are reviewing the guidelines for Depression. Agreement that this should go forward. It is not a Standard of Care. Guidelines to be reflective of input from all MTFs. Ms Kathy Kutscher to speak on this topic at the March 1999 meeting. Members are to contemplate also the idea of developing guidelines not only for the Primary Care Managers, but also for Mental Health Clinics within the Region. Subject was changed to reflect that this issue not only pertains to the PCMs, but also to Mental Health providers.
26 Feb 99: This item has been changed to include referral guidelines. There is a difference between the two, but both impact each other. There does not seem to be enthusiasm by the Primary Care Portals at NHB. "How to get staff involved" was discussed. This may be a “top down driven” issue at the individual MTFs. COL Brammer to bring topic forth to the MTF Medical Directors. Need to separate out guidelines and pathways. Referral guidelines are being worked at MAMC and this may be the way to start as individual departments may dictate when, where, and how a patient is referred for specialty services. There is a DoD/VA project to develop guidelines for VA and military services.
25 Mar 99: The members discussed this issue. Continue to have problems with the Primary Care Portals instituting the guidelines. A champion is needed in the portals. Medical Directors need to be made aware of this issue (COL Brammer to bring this issue to their attention at the next meeting). The members also discussed whether or not the Commanding Officer of each MTF should become involved
27 Aug 99: Family Practice providers at McChord are writing the scripts for the MH beneficiaries. Col Oliver (McChord DCCS) will be pushing for the development of a depression pathway. MAMC has reinstituted the training program for Family Practice and the Department of Medicine.
29 Oct 99: The members discussed this issue. It was decided that this issued will be tabled at this time until all resources (personnel and time) are available to develop the practice and referral guidelines. Clarification from the last entry is that McChord will incorporate the MAMC depression guidelines within its clinics. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0299	MHC WEB Page	LTC Voepel	ASSIGNED 23 Oct 98	COMPLETED 22 Jan 99	CLOSED

23 Oct 98: LTC Voepel will explore the feasibility of putting the MHC meeting minutes, agenda, and meeting schedule on the OTLA MHC WEB page.
20 Nov 98: Not discussed.
16 Dec 98: The MHC Web page is just about a go. LTC Voepel will notify the members when it is completed. The membership roster will also be posted after it is further revised. It is hoped that this meeting's minutes will be posted prior to the next meeting, so that members can provide feedback.
22 Jan 99: The minutes, membership roster, and presentations for the MHC are now on the NWLA intranet homepage. LTC Voepel will provide all members by e-mail the URL address and that he will notify them when new items are available for viewing. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0399	Treatment Plans	LtCol Drew All Members	ASSIGNED 21 Jan 99	COMPLETED	

21 Jan 99: Members discussed "Treatment Plans" for outpatient Mental Health Clinics. The TheraScribe Program automatically tracks the number of sessions and who needs to review the case. It also helps to develop the treatment plans. LtCol Drew is to forward to all members a copy of the Type 1 JCAHO finding from last Spring. All members need to place this on the forefront as JCAHO is inspecting these plans during an inspection. Members need to discuss the details of the process and what is needed to obtain and maintain compliance.
26 Feb 99: NHOH is researching the prospect of obtaining TheraScribe. CDR Hudack and others will attend a briefing on the system at McChord AFB on 10 Mar 99. Cost of the package for 5 users is $4500, which includes software and training.
25 Mar 99: LtCol Drew discussed the type I JCAHO findings. (See specific attachment) He also indicated that TheraScribe assisted in correcting the "findings" when treatment plans were submitted. CDR Hudak stated that he attended a demonstration of the TheraScribe system at McChord AFB earlier this month. He has decided to institute the system at NH Oak Harbor. The proposed package submitted includes 13 network PCs and three add-ons installed (includes training). He indicated that the primary advantages are ease of development of treatment plans, UM, and use of the eight visit model. The system adds structure, is the ideal short term treatment model, and allows the provider to examine long term cases. It is Microsoft compatible and meets JCAHO requirements. LtCol Drew indicated that each facility should examine the JCAHO Behavior Health Manual to ensure compliance.
29 Oct 99: This issue has been or is being resolved at each MTF through the use of either TheraScribe or another such system. It is anticipated that this issue will be closed after the JCAHO briefing given by MAMC personnel.

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0499	USCG Medical Care	MS Gray All Members	ASSIGNED 21 Jan 99	COMPLETED 29 Oct 99	CLOSED

21 Jan 99: Appears that there may be a problem not only in obtaining medical services for USCG, but also in the flow of information. Commands are not receiving information about members assigned to them nor is the Work Life Department being kept in the loop. There may be a need for a liaison and a case manager for the USCG. Unable to determine if the problem is internal, external, or both. Support from the MTFs is needed to resolve the issue.

26 Feb 99: Receiving support from both MAMC and NHB. Ms Gray is to attend the Behavioral Health Services meeting at MAMC on 11 Mar 99.
25 Mar 99: Ms Gray attended the Behavior Health Services meeting at MAMC earlier this month. An issue that has come up is the ability to track USCG personnel receiving care on the outpatient and inpatient basis. A subcommittee will be formed to look into this matter. The medical record is not always available when the member is seen nor when available is it complete.
30 Apr 99: As per the minutes for this meeting. There seems to be difficulty in obtaining feedback on active duty members being seen at other MTFs for chronic problems. USCG is to develop an overprint that will be part of the record and must be filled out by provider after the member is seen.
27 May 99: Determined that the USCG can view CHCS data at MAMC. Routine consults to psychiatrists are taking as long as 30 days at NH Bremerton and MAMC. CAPT Baer and COL Hicks are to examine the delay. CDR Bonneau (USCG) discussed the need for counseling to cope with life in general, especially for adults who were children of alcoholic parents or that were abused; more than short-term measures are needed. Treatment plans may not be feasible for implementation by the USCG because of the distance between where the member is stationed and the services offered. Fitness-for-duty is of concern, especially for those being seen by a civilian provider. There may be a need for a re-consultation to the MTF to determine if the member is fit-for-duty. All MTFs are to prepare a handout indicating what services are available. CAPT Baer indicated that OCIP program is available to the USCG. OCIP referrals need to be provided to NH Bremerton for screening and recommendations as to fit-for-duty status. The members agreed that a subcommittee does need to be formed to examine this and other problems that the USCG is facing. COL Hicks to chair the subcommittee.
25 June 99: USCG was instructed that if a referral for active duty is not made within 15 days, then the Chief of the Department (either NH Bremerton or MAMC) needs to be notified immediately.
29 Oct 99: As this issue is or may be discussed at each meeting under MTF updates the members decided that it should be closed as a separate tracking log issue. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0599	Group Health Transition	Ms Blackwood	ASSIGNED 21 Jan 99	COMPLETED 25 June 99	CLOSED

21 Jan 99: The membership decided that this topic needed to be presented/discussed at each meeting until the transition has been completed. Group Health provided both adult and child psychiatric services. 50-60% of the treatment was accomplished by the PCM under the Group Health model. Will not be able to determine the impact of this treatment model on the MTFs or the Network for several months. Group Health will continue to see beneficiaries until the transition is complete and/or all beneficiaries have a new provider.
26 Feb 99: There seems to be a developing problem with former Group Health beneficiaries trying to obtain prescription refills. Timely appointments with new PCMs appear to be one of the obstacles. This does not only apply to Psychiatry. LTC Vance stated that PsychCare (FHFS) is trying to hire a psychiatrist for the East Bremerton Clinic.
25 Mar 99: Continue to have problems with former Group Health patients being seen in the MTF. Medical records are not being transferred to MTFs. The members requested that LTC Voepel write a letter on behalf of the Consortium requesting that PsychCare (FHFS) obtain copies of records from Group Health of those patients being seen in the MTFs and forward them. This is especially important for the complex patients.
25 June 1999: The transition has been completed since 1 March 1999. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0699	Regional Child Mental Health	CDR Hudack	ASSIGNED 26 Feb 99	COMPLETED 29 Oct 99	CLOSED

26 Feb 99: The members decided that this issue needed to be tracked more closely as it is becoming more of a pronounced problem. The members discussed the issues. All service consultants need to be notified about the problem not only in Region 11, but also in all areas. Child Psychiatrist need to due a utilization tour at the end of the fellowship training. There seems to be a maldistribution of these practitioners. CAPT Baer brought to the attention to the members that the Navy priority is that these practitioners are assigned overseas and to areas that cannot buy the care, but that there is pressure to assign them to Washington D. C. and to San Diego. COL Hicks stated that MAMC is examining this as a long-term problem and will attempt to reallocate and shift resources to the Child Psychiatric area. The members decided that Dr Peterson (MAMC) needs to brief members on what is actually needed (services) for this region. He will be invited to the next one day meeting (April) if his schedule permits. The members also decided that a letter is needed to be sent to each of the consultants and the advisors for assignments.
30 Apr 99: The members discussed this issue at length and it was the primary topic for the meeting. The following is an account of what was discussed to include what services available, what is needed, problems noted, and recommendations. NH Bremerton (CAPT Baer and LCDR Richardson): A child psychiatrist is being assigned this summer. There seems to be a problem in obtaining network appointments (psychiatrist-4 months, psychologist-2 weeks) and obtaining hospitalization. Lynn Blackwood responded that the network provider screens the patient and determines when the patient will be seen. There has always been a problem in the Bremerton area in obtaining providers for the network. Another factor is that families are not willing to drive to Tacoma for treatment, although it is within the driving time. NH Oak Harbor (CDR Hudak): CDR Hudak is a Child Psychiatrist, but is filling a generalist slot. NHOH has numerous programs for children and adolescents, which are directed by a psychologist. There is only one child psychiatrist in the community. Working well with PsychCare. Attempting to recapture cases that would usually be referred into the network. Using MAMC for
neuro-psychiatric testing. MAMC (COL Hicks, MAJ Peterson, Mr.): MAJ Peterson is doing primarily child psychiatry. Resources are being allocated to support him. There appears to be an extensive wait for appointments in the network. Receives 15 new consultants each week and tries to keep half. Would like to a behavioral therapy specialist. A Pediatric Behavioral Clinic is part of Developmental Pediatrics and is a multidisciplinary approach. This clinic received 780 new consults in 1998 and 260 in the first four months of 1999. Would like to have more child psychologist in the community. USCG (Ms. Gray): Directly refers to PsychCare for referral of children and adolescents. May come to the attention of Ms. Gray when members/families call for an appointment. McChord (LTC Drew): Excellent Family Advocacy Program and an Outreach Program (group therapy). A significant increase in families eligible for EFMP, which are referred to MAMC. Fairchild (LTC Pugh, Maj Schack): All are referred downtown. PsychCare (Ms. Blackwood, Ms. Cochran): Ms. Blackwood informed the members of several specific items under CHAMPUS. There are no alternatives beyond RTC and acute admission at this time. The beneficiary must continuously show progress to remain in an RTC. RTC cost is $400 to $550 per day with an added cost of $40-$120 per day for educational services. Average length of stay is from 45 to 120 days in an RTC. Presently there are four RTCs that Region 11 can utilize. None are within the State of Washington. Discussion of the co-payments under TRICARE and TRICARE Prime was presented.
Recommendations/Needs: Institute resource sharing at MTFs. Use of alternative providers to psychiatrist, such as, Child Psychiatric Nurse Practitioners. Increase the number of support providers, such as, social workers, behavioral therapist, etc. Utilize military-trained Child Psychiatrist as such. Majority are now

being used as generalist for active duty members. Ensure promotable status if personnel stay within specialty.
25 June 99: The Child Psychiatrist that was to be assigned to NH Bremerton has been reassigned to Okinawa. NH Bremerton is pursuing to have this position filled.
27 Aug 99: The Child Psychiatrist for NH Bremerton is to arrive in May 2000. A TDA may be forthcoming in November 1999.
29 Oct 99: The TDA Child Psychiatrist for NH Bremerton will arrive the first week of November. MAMC is exploring and using resource sharing to increase the staff that supports its Child Psychiatrist. The members decided that this issue was closed and will be examined if necessary within the minutes under Old Business and/or MTF Updates. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0799	Integrated Process Team – Mental Health	COL Brammer	ASSIGNED 26 Feb 99	COMPLETED 29 Oct 99	CLOSED

26 Feb 99: COL Brammer briefed the members concerning the Integrated Process Team (IPT) on Mental Health. The IPT is examining the 9 cost saving initiatives that the Consortium responded to in December 1998, redesigning the Mental Health benefit, and the use of HMSI in all regions. Child Mental Health is also a big question for the team. COL Brammer is part of the team. He will be working with the Lead Agents concerning their input. The IPT welcomes all input from the field, especially the Consortiums. Members can join the meetings telephonically with the OTLA representatives. COL Brammer will provide feedback on a continuous basis.
25 Mar 99: COL Brammer gave an update from the Integrated Process Team meeting and the Working Integrated Process Team (WIPT). The members re-visited and discussed the cost savings initiatives (see Dec 98 meeting notes). The major topic revisited was how many visits should be allowed without a pre-authorization and a review of the treatment plan. A significant issue is how to protect the MTFs (bring beneficiaries into the direct care system) and still give a choice to the beneficiaries. The Consortium members could not decide on number of visits, but did indicate that two to four visits would not be unreasonable. At the 6 Apr 99 IPT meeting, the contractors will be asked how many visits do the beneficiaries actually receive (average) and a breakdown as to what percentage drops out after each visit. CAPT Baer reminded the members that if a treatment plan is required and reviewed by the contractor after "x" visits, then this standard will probably also be applied to the direct care system. Another issue that was brought up was the payment of services when a beneficiary is involuntarily admitted. The members agreed unanimously that TRICARE should pay these costs even if the facility is a non-creditialed (CHAMPUS, JCAHO, and/or CARF).
27 May 99: COL Brammer provided the members with an update. The eight visits will not changed, but that the provider will be required to notify the contractor to determine eligibility, provide diagnosis, and that proposed provider is appropriate. The 23 hour observation unit is to be incorporated. The IPT did not want to tackle the expanded in-home services nor the wrap-around program at this time. RTC education piece will not change as this is part of the CHAMPUS RTC requirement and pays what is billed. The IPT wanted to maintain the physician oversight of other mental health providers. The 365 day period for alcohol rehab will be eliminated in favor of a three episode lifetime limit with medical necessity review for each time of admission. Individual and/or group therapy for alcohol rehab as indicated by the contractor is being discussed further. No change in the need for CHAMPUS certification, in favor of JCAHO or CARF certification, as other certification process and guidelines are not as strict. CHAMPUS certification requirements will be re-examined. Therapy sessions for inpatients will be expanded to one day.
29 Oct 99: The Work Simplification Plan has been developed and forwarded for consideration. As this issue will be discussed either under Old Business or MTF Updates in the future as needed, COL Brammer

and the other members of the Consortium decided to close this item as a separate tracking log issue. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0899	VA Services	COL Hicks CAPT Baer COL Brammer	ASSIGNED 26 Feb 99	COMPLETED 29 Oct 99	CLOSED

26 Feb 99: CAPT Baer brought to the attention of the members about using the VA (Seattle) when the MAMC inpatient unit is closed to admissions. FHFS does have an approved contract with VA hospitals in the Northwest. This issue needs to be explored. Members would like a tour of American Lakes (VA) and a briefing concerning the services available/how to obtain. The members also discussed the possibility of having the VA represented on the Consortium.
25 Mar 99: The members discussed using the VA for active duty members. The contract that PsychCare has with the VA is for beneficiaries other than active duty. A separate contract would need to be developed. This will be elevated as a regional issue. COL Brammer will contact the VA Chief of Staff, Dr Chuck Smith for details and costs. The members also decided that the VA should not become a member of the Consortium as it is a subcontractor. The VA can be invited as a guest to brief what services are available and any research programs that can participated in by TRICARE beneficiaries.
30 Apr 99: Ms. Blackwood gave a presentation concerning the VA contract. (See appendix C under this month's meeting minutes.) The contract is not signed as of yet. PsychCare will need to educate VA providers concerning managed care. Tacoma VA (American Lakes) does not want to treat inpatients under the contract. PsychCare will visit each site and provide a template to the Consortium as what services each site is willing to provide. All mental health services are not accessible at each facility.
27 May 99: The VA contracts with PsychCare have been signed.
27 Aug 99: COL Brammer and COL Hicks reported on a visit to the VA Hospital at American Lakes. It appears that this VA Hospital will be unable to provide care for Active Duty on an ongoing basis (contract), but will assist (if possible) on a case-by-case standpoint. This is due to shortages of personnel, space, etc.
29 Oct 99: This issue was mainly to examine the use of the local VA institutions within the Puget Sound area, Seattle and Tacoma. Neither facility is able to assist on a consistent basis, but as noted previously each case will be weighed upon merit, staffing, etc. The members decided that this issue did not encompass all VA services within the Region. Managed Health Network will advise the members as to the availability of VA services and changes to such during the MTF updates at each meeting. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-0999	Involuntary Admissions	LTC Nystrom LCDR Richardson	ASSIGNED 25 Mar 99	COMPLETED 29 Oct 99	CLOSED

25 Mar 99: The members discussed the requirements for an active duty member being involuntarily admitted to a psychiatric unit in a MTF. Involuntary admissions are governed by DoD 64-90. The issue is to ensure that the process is the same for all MTFs within the region, especially when an active duty member is transferred from one MTF to another.
30 Apr 99: A question that was raised by the group during the VA briefing was whether or not an active duty member can be admitted involuntarily to the VA under the judgement of the provider in the MTF, but in the judgement of the State that the person does not need hospitalization? The revised DoD policy on Involuntary Admissions (Jan 99) needs to be obtained, distributed to the members, and incorporated in all MTF policies.
27 May 99: LTC Voepel distributed the DoD policy prior to the meeting and distributed the MAMC policy regarding "Mental Health Referrals for Soldiers". COL Hicks indicated that the MAMC policy would

need to be revised and updated. The members discussed involuntary admissions for both non-active duty beneficiaries as well as the active duty member. State law prevails for the non-active duty member, i.e., the county mental health provider ultimately determines if a person needs to be involuntarily admitted. If this is contrary to what the MTF staff believes, then thorough documentation needs to take place and perhaps a second opinion should be ordered. The main focus of the discussion was on how to transport the active duty member. Mechanisms open for the means of transportation are duty driver with a mental health technician and a person from the members command; transport by military ambulance, especially if chemical restraints are used; and to buy the service locally. The MOU between NH Bremerton and MAMC will need to be revised so that the military ambulance from MAMC can be used for Navy personnel. COL Hicks also approached the group with the proposal of having both active duty and non-active duty beneficiaries sign a voluntary admission form. A Western Regional Medical Command (Army) policy needs to be developed for the use of the voluntary admission form. The policy will then be offered to the other MTFs to be initiated as an SOP. This policy will cover both the voluntary and involuntary admission.
29 Oct 99: As this issue has been incorporated into MHC-0898, the membership decided to close this specific item. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-1099	Impact of Unfilled Positions	All Members	ASSIGNED 30 Apr 99	COMPLETED 29 Jan 99	CLOSED

30 Apr 99: See minutes for details. The members recognize that there is a potential for problems due to the impact of unfilled or deleted positions within the MTFs. Members are to discuss and devise ways and means to minimize these actions. First project is the unfilled psychiatrist position at Fairchild AFB as of 1 July 99.
27 May 99: Maj Schack stated that the 92nd is exploring the use of reservist (psychiatrist) at Walla Walla VA. If the 92nd were willing to pay for the TDY of a provider, then this would also be a possibility. COL Brammer introduced the idea of short term resource sharing; the 92nd is to explore this also.
25 June 99: MAMC is down two psychiatrists; using resource sharing to fill one of the positions. An active duty social worker is to be assigned in September. Fairchild lost the contracted social worker and a replacement will not be forthcoming.
27 Aug 99: There seems to be a consensus of all members that personnel shortages are having an effect on the Region. Although Active Duty members are being seen, non-Active Duty beneficiaries are being referred to PsychCare. Many of the MTFs are examining resource-sharing projects to bring the latter group of beneficiaries back into the MTFs.
29 Oct 99: As this specific issue is discussed each month in the minutes under MTF Updates, the membership decided to close the issue. **CLOSED**

LOG #	SUBJECT	ACTION OFFICER	DATE	DATE	FOLLOW-UP
MHC-1199	Combat Stress Control Program	All Members	ASSIGNED 30 July 99	COMPLETED	As Needed

30 Jul 99: Members received a briefing on the Combat Stress Control Program from MAJ Doyle. All services are to develop an integrated system. Members are to forward information to LTC Voepel for dissemination and to put on agenda for discussion.
29 Oct 99: This item remains open as new information concerning the program should be forthcoming in the immediate future.